STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Health & Rehab Center	**610 West Fisher Street , Salisbury, North Carolina, 28145**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 9/8/2025 to 9/11/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D5BE4-H1.	E0000		09/25/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/8/2025 to 9/11/2025. Event ID # 1D5BE4-H1. The following intakes were investigated: 847493 and 847492. 5 of 5 complaint allegations did not result in deficiency.	F0000		09/25/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	F0550 Corrective Action for the affected resident Resident #30 was promptly met by the Assistant Director of Nursing on 9/10/2025 to discuss the incident and validate Resident #30 feelings regarding being spoken to in an undignified manner. The Assistant Activity Director immediately excused herself from the 9/10/2025 Resident Council meeting. The Administrator educated the Assistant Activity Director regarding procedures for addressing resident concerns during the Resident Council Meeting. Topics included: Mediation and resolution by offering mediation with a subsequent follow-up session with a neutral staff member if the resident concern is not resolved during the meeting.	10/09/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to ensure a resident was spoken to in a dignified manner when the resident expressed feelings of being frustrated and felt like he was spoken to in a childlike manner. This affected 1 of 3 residents reviewed for dignity and respect (Resident #30). The findings included: Resident #30 was admitted to the facility on 06/27/18. Resident #30's quarterly Minimum Data Set (MDS) dated 07/18/25 revealed the resident was cognitively intact. The resident was not documented as having behaviors. An observation was conducted during a resident council meeting on 09/10/25 at 2:25 PM in a small room with ten residents present sitting facing the Activity Assistant. The door to the room was opened to the hall. Resident #30 voiced the door needed to be closed during the meeting for privacy. Resident #30 attempted to explain to the Activity Assistant the door to the room needed to be closed so that the meeting could be private and issues could be discussed privately. The Activity Assistant was sitting in a chair and told Resident #30 to "calm down" in a condescending tone and did not shut the door. Resident #30 was observed shaking his head, and had a furrowed brow, and raised his voice stating, "She [The Activity Assistant] did not listen to the residents, and I am tired of being spoken to like a child." The Activity Assistant then rolled her eyes and stated to Resident #30 again to	F0550	Continued from page 1 Support and follow-up by offering access to filing a grievance, a social worker referral and any staff assistance while protecting resident dignity, privacy and reinforcing a positive culture. Resident #30 was reassured of their rights and offered emotional support services by the Social Worker, including access to the grievance process and counseling if desired. Identification of Other Potentially Affected Residentse Activity Director interviewed all residents who attended the 09/10/25 resident council meeting to determine if they felt disrespected or observed undignified staff behavior. No other residents were identified who expressed issues with staff demeanor, tone, or treatment. Residents did not report any issues with undignified treatment. Measures to Prevent Recurrence All personnel and new hires will undergo mandatory in-service training on: Resident Rights (F550) Training will be completed by October 9, 2025, and documented in RELIAS and staff education logs. Resident Rights will continue to be an area of focus for new hires during orientation on an ongoing basis. The Administrator or designee will ask to be added to the Resident Council meeting calendar to attend Resident Council meetings for the next three months to observe staff interactions and provide 1:1 education if needed. Staff behavior will be monitored during the Resident Council meeting through direct observation and resident feedback by the Administrator. Any recurrence will result in progressive discipline per center policy. 4. Monitoring and Quality Assurance Nine (9) department managers will conduct weekly audits of 5 staff-resident interactions for 8 weeks then monthly for 3 months using a daily rounds checklist. The Resident Council will include a standing agenda item for feedback on staff communication and dignity concerns per agreement with the Resident Council	

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F0550 SS = D	Continued from page 2 "calm down." Resident #30 and other residents appeared to have a confused look on their faces and did not say anything to the Activity Assistant. The Activity Assistant excused herself from the meeting to allow the residents to have a private meeting without staff present. The Activity Assistant shut the door on her way out. An interview conducted Resident #30 on 09/11/25 at 8:45 AM revealed on 09/10/25 he got upset because he felt that the Activity Assistant spoke to him like a child when she told him to "calm down" and felt she could care a less what concerns residents had. Resident #30 indicated he was frustrated and was glad the Activity Assistant had left the meeting so that residents could speak freely and not feel like anything would be used against them. An interview with the Activity Assistant on 09/11/25 at 8:40 AM revealed she did not usually participate in resident council meetings but had been conducting them because the Activity Director had been out since the beginning of August. The Activity Assistant indicated on 09/10/25 during the resident council meeting she was surprised Resident #30 had gotten upset because she did not think she had acted toward resident in a negative manner. The Activity Assistant revealed she was not aware she had spoken to the resident in an undignified manner nor was she aware she had rolled her eyes. The Activity Assistant stated if she did roll her eyes or have a tone it was because she was caught off guard and was shocked when Resident #30 had been so vocal. It was further revealed she told Resident #30 to calm down because she felt that he was getting worked up. In an interview with the Administrator on 09/11/25 at 2:20 PM she revealed she expected staff to walk away if situations escalated and not to reply in an unprofessional manner. It was further revealed she expected all staff to treat residents with dignity and respect.	F0550	Continued from page 2 President for the next 3 months. The QAPI Committee will review all dignity-related incidents monthly for and adjust training or protocols as needed on an ongoing basis. 5. Responsible Party The Administrator and Director of Nursing will oversee implementation and compliance with this plan of correction with a completion date of 10/09/2025.	
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the	F0578	F0578 Corrective action for the affected residents The Director of Nursing (DON) and Assistant Director of Nursing (ADON) have reviewed and updated the advance directive documentation for Residents #15 DNR status and #18 FULL code status to ensure consistency across the physician's orders, face sheet, MAR, Advance Directive book at nurses' station and MOST/DNR forms.	10/09/2025

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F0578 SS = D	Continued from page 3 provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to update 2 of 3 residents advance directive information (Resident #15 and Resident #18). The findings included: 1. Resident #18 was admitted to the facility on 05/15/25. A review of Resident #18's orders for advance directives revealed a physician's order dated 05/15/25 for Do Not Resuscitate (DNR, an order signed by a doctor that informs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a person's breathing stops or their heart stops beating).	F0578	Continued from page 3 All discrepancies were corrected in the Matrix electronic medical record system and verified against hard copy documentation by the DON & ADON. Identification of other potentially affected residents A full audit of all residents' advance directive documentation was initiated on 09/11/25 and completed by 09/19/2025 by the DON, Social Worker and the ADON. Any inconsistencies identified were immediately corrected, and documentation was aligned across all platforms (face sheet, Advance Directive book at nurses' station, physician's orders, MOST/DNR forms, and the MAR) by the DON. Measures to prevent recurrence On 09/22/25, mandatory in-service training was initiated for all licensed nursing staff, including DON, ADON, MDS Nurse, Social Worker and charge nurses by the Regional Clinical Nurse Training covered: Importance of accurate and consistent documentation of advance directives. Procedures for updating physician's orders when MOST/DNR forms are signed or modified. Verification protocols during admission and any change in code status. Monitoring and Quality Assurance Weekly audits of 7 resident charts will be reviewed for advance directive documentation compliance by the ADON/designee for the next 8 weeks beginning 09/11/25 then monthly for 3 months of 10 resident records to ensure ongoing compliance in advance directive documentation across all records. Results of the audit will be reviewed during the 9/26/2025 Quality Assurance and Performance Improvement (QAPI) meeting then monthly for 3 months with the goal being zero discrepancies found in the audits.	

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F0578 SS = D	Continued from page 4 A review of Resident #18's face sheet and Medical Orders for Scope of Treatment (MOST) form dated 06/25/25, and both indicated he was a full code (meaning to perform life saving measures including CPR). An interview conducted with the Assistant Director of Nursing (ADON) on 09/09/25 at 12:10 PM revealed Resident #18 was initially admitted with orders to be a DNR but was recently changed to a full code status. The ADON further revealed she and the Director of Nursing (DON) updated and reviewed orders and should have caught that Resident #18's advance directives order had not been updated. During an interview conducted with the Director of Nursing (DON) on 09/11/25 at 9:20 AM, the DON stated Resident #18's physician order, face sheet, and MOST form should have matched. The DON further revealed the order in Resident #18's chart should have been updated to reflect the current MOST form for the resident to be a full code. An interview conducted with the Administrator on 09/11/25 at 2:20 PM revealed she expected advance directive information to match so that nursing staff had no confusion about what to follow in case of an emergency. It was further revealed Resident #18's physician order should have been updated to accurately match the resident's choice for code status. 2. Resident #15 was admitted to the facility on 8/23/2025 with diagnosis of a seizure disorder. During a review of Resident #15's orders for advance directives a physician's order dated 8/23/25 indicated he was a full code. A review of Resident #15's face sheet, Do Not Resuscitate Form, and Medical Orders for Scope of Treatment (MOST) form were dated 8/23/25 and indicated he was a Do Not Resuscitate. An admission Minimum Data Set assessment dated 8/27/25 indicated Resident #15 was cognitively intact. On 9/10/2025 at 9:56 AM Nurse #1 was interviewed, and she stated Resident #15's face sheet stated he was a DNR, and his physician's orders indicated he was a full code. Nurse #1 stated Resident #15's face sheet, Do Not Resuscitate form, and the physician's orders should match. An interview was conducted with the Assistant Director	F0578	Continued from page 4 Any discrepancies will be addressed immediately, and staff involved will receive targeted 1:1 re-education by the DON/designee.	

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F0578 SS = D	Continued from page 5 of Nursing on 9/10/25 at 12:04 PM and she stated each time a residents' code status changed she updated the book (where the DNR forms are kept at the nurses' station) to reflect the change. The book, face sheet and physicians' orders should match to reflect the residents' advance directives wishes. The Assistant Director of Nursing stated Resident #15's advance directives were to be DNR, but she failed to update the advance directives physician's order in the computer. The Director of Nursing (DON) was interviewed on 9/11/25 at 11:53 AM and she stated Resident #15's advanced directives physician's orders, face sheet, and the DNR form should have matched. The DON stated the physician's order should have been updated by the Assistant Director of Nursing when the DNR form was signed by the physician. On 9/11/2025 at 1:45 pm the Administrator was interviewed and stated the nursing staff should ensure each residents' advance directives matched in the advance directives book at the nurses' station, and on the resident's face sheet and physician's orders to ensure the nurses were aware of the correct advance directives for each resident.	F0578		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide nail care for 3 of 4 residents that were dependent on staff for personal care (Resident #2, Resident #26, and Resident #18). Findings included: 1. Resident #2 was admitted to the facility on 5/23/2025 with heart disease and weakness. A quarterly Minimum Data Set assessment dated 8/4/2025 indicated Resident #2 was cognitively intact and required extensive assistance for personal hygiene. The assessment documented the resident did not have impairment to range of motion for the upper extremities.	F0677	F0677 Corrective Action for the affected residents Nail care for Residents #26, and #18 was completed by licensed nursing staff immediately following the identification of the need for cleaning and trimming of their nails on 09/08/2025. Identification of other potentially affected residents All residents requiring assistance with both hands and feet nail care were assessed by the DON and ADON to ensure that all resident nails were trimmed, filed and cleaned with documentation completed by 09/18/2025. The audit included inspection of both hands and feet nail length and cleanliness, with corrective care provided as needed by the licensed nurses. Documentation was reviewed by the DON to ensure both hands and feet nail care was reflected on the individual shower sheets.	10/09/2025

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F0677 SS = D	Continued from page 6 On 9/8/2025 at 11:43 am Resident #2 was observed in his room in bed, he had a dark brown substance under his nails, and the free edge of the nails were approximately ¼ inch beyond the tip of the fingers for all 10 fingers. Resident #2 stated he received a shower twice a week and on days he does not receive a shower he was given a bed bath, but they did not clean under his nails after his showers, or after a bed bath, and he did not like for his nails to be long and dirty. On 9/8/2025 at 11:59 am an interview was conducted with Nurse Aide #2 who was assigned to Resident #2. Nurse Aide #2 stated Resident #2 required extensive assistance with nail care but did not refuse care. She stated Resident #2 was not scheduled for a shower on 9/8/25. She explained she had not noticed his nails had a dark brown substance under them and that they were long. Nurse Aide #2 stated Resident #2 did not tell her his nails needed to be trimmed and cleaned. An interview was conducted with Nurse #1 on 9/10/2025 at 9:43 am and she stated the Nurse Aides were responsible for cleaning and trimming residents' nails during their showers and when needed. During an interview with the Assistant Director of Nursing on 9/10/2025 at 9:52 am she stated the Activities Department does provide manicures on Thursday for residents that request a manicure, but the Nurse Aides should be cleaning and trimming the residents' nails when they provide the residents' showers as scheduled. The Director of Nursing was interviewed on 9/11/2025 at 11:57 am and stated the nurse aides and nurses were responsible for cleaning and trimming residents' nails with each shower and as needed. On 9/11/2025 at 1:45 pm the Administrator was interviewed, and she stated the residents' nails should be cleaned and trimmed with each shower and as needed. 2. Resident #26 was admitted to the facility on 6/12/2025 with diagnoses of fracture of the right humerus (the bone in the upper arm), stroke, and hemiplegia (weakness of one side of the body). An admission Minimum Data Set assessment dated 6/17/2025 indicated Resident #26 was cognitively intact and required extensive assistance for personal hygiene. The assessment further indicated Resident #26 had weakness to his upper and lower extremities on one side.	F0677	Continued from page 6 Measures to prevent recurrence Mandatory education was initiated on 09/25/25 for all Nurse Aides, Nurses, and the interdisciplinary care team by the DON. Newly hired nursing staff and members of the interdisciplinary team will be educated on proper hands and feet nail care to include cleaning, filing and trimming the nails with the hygiene focus area being added to the new orientation checklist on an ongoing basis. Topics included: Proper hands and feet nail care procedures for all residents to include trimming, filing and cleaning their nails. Protocols for documenting that the residents received hands and feet nail care by the CNA to include trimming, filing and cleaning their nails. CNAs are responsible for completing nail care or reporting the need for nail care to the Nurse as they are not responsible for providing diabetic nail care. Policy review initiated on 9/25/2025 to ensure consistent hygiene and comfort for all residents--nail care will now be provided as needed by CNAs on the resident designated shower day 2 times per week to include trimming, cleaning and filing fingernails and toenails This review will be added to the new hire orientation checklist. DON/designee will review 100% of the shower sheets daily for 8 weeks then random audits of the individual shower sheets for 3 months. DON/designee will observe Indvidual resident actual nails at a rate of 3 residents per week for 8 weeks then monthly for 3 months to ensure all residents receive regular and hygienic nail care as part of their ADLs. Monitoring and Quality Assurance Weekly nail hygiene audits will be conducted by reviewing the shower sheets by the Assistant Director of Nursing for 8 weeks beginning 09/11/25 then monthly for 3 months. Nail audit results will be reviewed during monthly QAPI meetings.	

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F0677 SS = D	Continued from page 7 During an observation of Resident #26 on 9/8/2025 at 12:39 pm the free edge of his fingernails were approximately ¼ inch beyond the tip of the finger and he stated his nails were trimmed when he was admitted to the facility but had not been trimmed since his admission. Resident #26 stated he did not like his nails to be long. On 9/8/2025 at 11:59 am an interview was conducted with Nurse Aide #2 who was assigned to Resident #26. Nurse Aide #2 stated Resident #26 was dependent on staff for nail care and all personal hygiene, and he did not refuse nail care. Nurse Aide #2 stated she had not given Resident #26 a shower on the day of the interview and was not aware his fingernails extended approximately ¼ inch long beyond fingertips. Nurse Aide #2 stated Resident #26 did not tell her his nails needed to be trimmed. An interview was conducted with Nurse #1 on 9/10/2025 at 9:43 am and she stated the Nurse Aides were responsible for cleaning and trimming residents' nails during their showers and when needed. During an interview with the Assistant Director of Nursing on 9/10/2025 at 9:52 am she stated the Activities Department does provide manicures on Thursday for residents that request a manicure, but the Nurse Aides should be cleaning and trimming the residents' nails when they provide the residents' showers as scheduled. The Director of Nursing was interviewed on 9/11/2025 at 11:57 am and stated the nurse aides and nurses were responsible for cleaning and trimming residents' nails with each shower and as needed. On 9/11/2025 at 1:45 pm the Administrator was interviewed, and she stated the residents' nails should be cleaned and trimmed with each shower and as needed. 3. Resident #18 was admitted to the facility on 05/15/25 with diagnoses which included type 2 diabetes, acute kidney failure, muscle weakness, chronic pain, and hypertension. Resident #18 quarterly Minimum Data Set (MDS) dated 06/19/25 revealed the resident was cognitively intact and required substantial and maximal assistance with personal hygiene. Resident #18's care plan revised on 07/15/25 revealed the resident was at risk for activities of daily living	F0677	Continued from page 7 Any nail audit discrepancies will be addressed immediately, and staff involved will receive targeted re-education by the DON,	

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F0677 SS = D	Continued from page 8 (ADL) self-care and mobility deficits. Resident #18's goal was his needs would be met with assistance if needed. Interventions included to check Resident #18's nail length, trim, and cleaning as needed. An interview and observation conducted with Resident #18 on 09/08/25 at 11:50 AM revealed the resident voiced complaints that his fingernails were long, and he had recently asked staff to trim them, but they had not been trimmed yet. Observations further revealed Resident #18's fingernails to be an estimated one inch long from the base to the tip of the nail with a brown substance under his nails. Resident #18 stated Nurse Aides (NAs) would not trim his fingernails because he was diabetic. An interview conducted with Nurse Aide (NA) #5 on 09/10/25 at 10:55 AM revealed she did not perform nail care on Resident #18 due to the resident being a diabetic. NA #5 further revealed she assisted Resident #18 with bathing and other hygiene needs but could not recall the length and shape of his nails. NA #5 stated the Activity Director (AD) or Nurses performed nail care for diabetic residents. NA #5 revealed if she had observed Resident #18's fingernails to be long she would have reported it to the assigned Nurse. An interview conducted with the Assistant Director of Nursing (ADON) on 09/09/25 at 12:10 PM revealed she had trimmed Resident #18's fingernails on this date due to being long. The ADON indicated that the Activity Director (AD) had been out of work since the beginning of August and normally did rounds and conducted nail care for all residents. The ADON stated Resident #18 had diabetes and Nurse Aides (NA) were not permitted to perform the care. ADON revealed the NAs should have reported long fingernails to nurses to assure nail care was being provided. Interview conducted with the Director of Nursing (DON) dated 09/01/25 at 10:35 AM revealed she was not aware Resident #18's fingernail had not been trimmed. The DON further revealed she expected all staff to observe residents and complete hygiene needs.	F0677		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and	F0695	F-Tag 0695 Correction action for the affected residents Oxygen "In Use" signage was immediately posted on the doors of Resident #25 and Resident #38 upon identification by the DON on 9/10/2025.	10/09/2025

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F0695 SS = D	Continued from page 9 tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to post cautionary signage for oxygen in use for 2 of 3 residents reviewed for respiratory care (Resident #25 and Resident #38). Findings included: 1. Resident #25 was admitted to the facility on 8/22/2025 with diagnosis of respiratory disease. A Physician's Order dated 8/22/2025 indicated Resident #25 should be administered 2 liters of oxygen by nasal canula continuously. A Minimum Data Set admission assessment was in progress but not completed for Resident #25. The care plan for Resident #25 dated 8/22/2025 indicated he required oxygen continuously for respiratory disease. On 9/8/2025 at 12:27 pm an observation was conducted of Resident #25, and he was in bed, and his oxygen was delivered by nasal canula. Resident #25 did not have signage to designate he had oxygen in use posted on his room door. On 9/10/2025 at 10:00 am an observation was made of Resident #25 in bed with his oxygen delivered by nasal canula, without signage on his room door to designate he was on oxygen. Nurse #1 was interviewed on 9/10/2025 at 10:03 am and she stated Resident #25 should have an oxygen sign on his door and the nurse was responsible for placing the oxygen in use signage on the resident's door. Nurse #1 stated Resident #25 had orders for continuous oxygen. The Hospice Nurse was interviewed on 9/10/2025 and she stated Resident #25 was required hospice services due to a diagnosis of chronic respiratory disease and required oxygen continuously for comfort. During an interview with the Director of Nursing on 9/11/2025 at 11:57 am she stated Resident #25 should have signage to designate he had oxygen on his room door since he received oxygen, and the nursing staff	F0695	Continued from page 9 Identification of other potentially affected residents A facility-wide audit was conducted by the DON and the ADON to ensure all residents receiving oxygen therapy had appropriate signage posted on 09/10/2025. Measures to prevent recurrence All staff, including licensed nurses and the interdisciplinary team were re-educated by the DON on 09/30/2025 topics included: The importance of posting oxygen signage for residents receiving oxygen therapy. Regulatory requirements for oxygen safety. Inclusion of signage verification during daily concierge rounds. The facility's Oxygen Administration Policy was reviewed to include oxygen signage placement on the resident's doorway during initiation of oxygen therapy. Clear, durable signs for "No Smoking Oxygen in Use" to be placed on entry doors by the Maintenance Director by 10/09/2025. Monitoring and Quality Assurance The DON or designee will conduct weekly audits of all residents requiring Oxygen for 8 weeks, then monthly for 3 months, to ensure compliance with oxygen signage requirements. Audit results will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing oversight and compliance. Any noncompliance will trigger immediate 1:1 corrective action and re-education.	

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F0695 SS = D	Continued from page 10 was responsible for ensuring the signage was on the resident's room door. An interview was conducted with the Administrator on 9/11/2025 at 1:45 pm and she stated residents that receive oxygen should have signage on their door designating they were on oxygen. 2. Resident #38 was admitted to the facility on 06/27/25 with diagnoses which included unspecified acute lower respiratory infection, acute cough, wheezing, and congestive heart failure. Resident #38's quarterly Minimum Data Set (MDS) dated 07/07/25 revealed the resident was cognitively intact. Physician order dated 09/08/25 revealed Resident #38 was ordered oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. An observation on 09/09/25 at 12:25 PM revealed Resident #38 was observed in her room sitting in her wheelchair with oxygen on. The Resident stated she was getting ready to leave for an outing. The observation indicated no oxygen signage outside the door. An observation on 09/10/25 at 10:00 AM revealed Resident #38 was observed in her room sitting in her wheelchair with oxygen on. The observation further revealed no oxygen signage outside the door. An observation and interview conducted with the Assistant Director of Nursing (ADON) on 09/10/25 at 11:40 AM indicated she was not aware Resident #38 did not have any oxygen signage up. The ADON further revealed she and the Director of Nursing (DON) normally post oxygen signage but must have missed it. The ADON indicated all residents who received oxygen were expected to have oxygen signage. An interview conducted with the Director of Nursing (DON) 09/11/25 at 9:20 AM revealed they were unaware Resident #38 did not have oxygen in use signage posted outside of their room. The DON indicated she was aware Resident #38 had been using continuous oxygen. It was further revealed the DON expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms.	F0695		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812	F0812 Corrective action for affected residents	10/09/2025

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F0812 SS = E	Continued from page 11 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and Dietitian and staff interviews, the facility failed to label and date leftover food items stored for use in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer and the dry goods storage area and failed to maintain clean food service equipment and flooring and failed to clean a thermometer probe before inserting the probe into food. These practices had the potential to affect food served to residents. The findings included: a. An observation of the walk-in refrigerator on 9/8/25 at 10:30 AM revealed an undated package of sliced ham that was not sealed. b. An observation on 9/8/25 at 10:41 AM revealed an open-to-air bag of chicken patties sitting in an open box, in the walk-in freezer and 4 bags of leftover hoagie rolls unlabeled and undated. c. An observation of the dry goods storage room on 9/8/25 at 10:50 AM revealed a bag of breadcrumbs in a clear plastic bag that was unlabeled and undated.	F0812	Continued from page 11 The Certified Dietary Manager labeled and dated all of the 9/8/2025 leftover food items in the cooler, freezer, and dry goods storage on 9/8/2025. The CDM continued daily cleaning of all of the food service equipment and all of the kitchen flooring on 9/08/2025. The thermometer probe was sanitized by the Cook on 9/10/2025 and prior to each use as is customary. Identification of other potentially affected residents All improperly stored or unlabeled food items were immediately discarded on 09/08/2025 by the Dietary Manager. All food service equipment (plate covers, tea/coffee machines) and dry storage floors were Deep Cleaned on 09/10/2025 by the Dietary Manager. Cook #1 was reeducated on thermometer sanitation protocols and observed for compliance by the Dietary Manager on 9/10/2025. A sanitation checklist was implemented for daily monitoring of food storage and equipment cleanliness by the Administrator to be completed 10/09/2025. Measures to prevent recurrence The Administrator educated the Dietary Manager on 9/25/2025 after noting the Sanitation grade of 100 for the kitchen on maintaining the grade to ensure all items in the kitchen are labeled and dated appropriately, maintaining clean food service equipment and floors, and that thermometer probes are cleaned before inserting the probe into the food. All dietary staff will receive initiated, ongoing education training by the Dietary Manager with attendance by the Administrator by 10/9/2025. Topics to include: Proper labeling and dating of food items upon opening. Safe food handling practices, including thermometer sanitation.	

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F0812 SS = E	Continued from page 12 An interview with the Dietary Manager (DM) on 9/8/25 at 10:53 AM indicated that whichever staff opened the packages they should label and date immediately when they are opened. She further stated that when taking the opened boxes from the kitchen to the freezer they should be inspected to make sure they were securely closed d. An observation of the plate covers on 9/10/25 at 11:57 AM prior to serving the line revealed the plate covers were dirty with food crumbs. e. An observation on 9/10/25 at 12:00 PM revealed Cook #1 removed a thermometer stored in a pitcher of ice to obtain the internal temperature of foods items. The thermometer probe was noted to have yellow food particles; the Cook proceeded to insert the thermometer probe into the creamed corn. Cook #1 did not clean the thermometer probe before inserting it into the creamed corn. An interview with Cook #1 on 9/10/25 at 12:00 PM indicated when asked about the cleaning of the thermometer, she said she was nervous and forgot to clean the probe and that she had just tested the food temperatures with the Dietitian and was trying to get the food ready to serve on time. An interview with the Dietary Manager on 9/10/25 at 12:26 PM revealed that the Dietitian had been in the kitchen prior and checked the food temperatures and that was why the thermometer probe contained food particles. She then revealed that Cook #1 had worked in the kitchen for 15 years and was just nervous, that she had done this thousands of times and always had her cloth and alcohol swabs laid out to clean the thermometer probe. An interview with the Dietitian on 9/10/25 at 3:00 PM indicated that she had been in the kitchen and had tested the food temperatures and that Cook #1 usually followed the correct procedure for taking the temperature of foods. f. Observations of the tea and coffee machines on 9/8/25 at 11:00 AM and 9/10/25 at 11:50 AM revealed the machines had dried splattered stains and sticky to	F0812	Continued from page 12 Daily cleaning protocols for equipment and storage areas. Monitoring and Quality Assurance A “Label & Date” policy was posted in all food storage areas by the Administrator on 10/1/2025. A daily sanitation log was implemented by the Dietary Manager ad reviewed by the Administrator on 9/30/2025 for the: Cooler and Freezer Dry goods storage Food service equipment Thermometers storage The Dietary Manager will perform weekly audits for 8 weeks, then monthly thereafter for 3 months to ensure compliance with cleanliness, thermometer storage/cleanliness and labeling of food items. Audit results will be reviewed during monthly QAPI meetings. Any noncompliance will trigger immediate 1:1 retraining and corrective action by the Dietary Manager. The Administrator will oversee implementation and ensure sustained sanitation compliance of the dietary department.	

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F0812 SS = E	Continued from page 13 touch substances on the outside walls and dried brown matter on the bottom. g. The dry goods storage area flooring was observed on 9/10/25 at 11:53 AM to have dirt, food debris and dust underneath the shelves. An Interview with the Dietary Manager on 9/10/25 at 2:54 PM revealed that the weekend staff did not clean well and she had to have a discussion with them so that they did a better job with cleaning. The DM further indicated that the dry good storage area floors were to be cleaned daily. An interview with the Administrator on 9/10/25 at 3:30 PM indicated that she expected the procedures in the kitchen to be correct and careful attention paid to food service to make sure the food not only tasted good but was sanitary and safe. The Administrator further stated she would talk with the Dietary Manager to make sure these corrections were made.	F0812		